



STATE OF MARYLAND

DMMH

Maryland Department of Health and Mental Hygiene
300 W. Preston Street, Suite 202, Baltimore, Maryland 21201

Martin O'Malley, Governor – Anthony G. Brown, Lt. Governor – Joshua M. Sharfstein, M.D., Secretary

Office of Preparedness & Response

Sherry Adams, Director

Isaac P. Ajit, Deputy Director

August 17, 2012

Public Health & Emergency Preparedness Bulletin: # 2012:32 Reporting for the week ending 08/11/12 (MMWR Week #32)

CURRENT HOMELAND SECURITY THREAT LEVELS

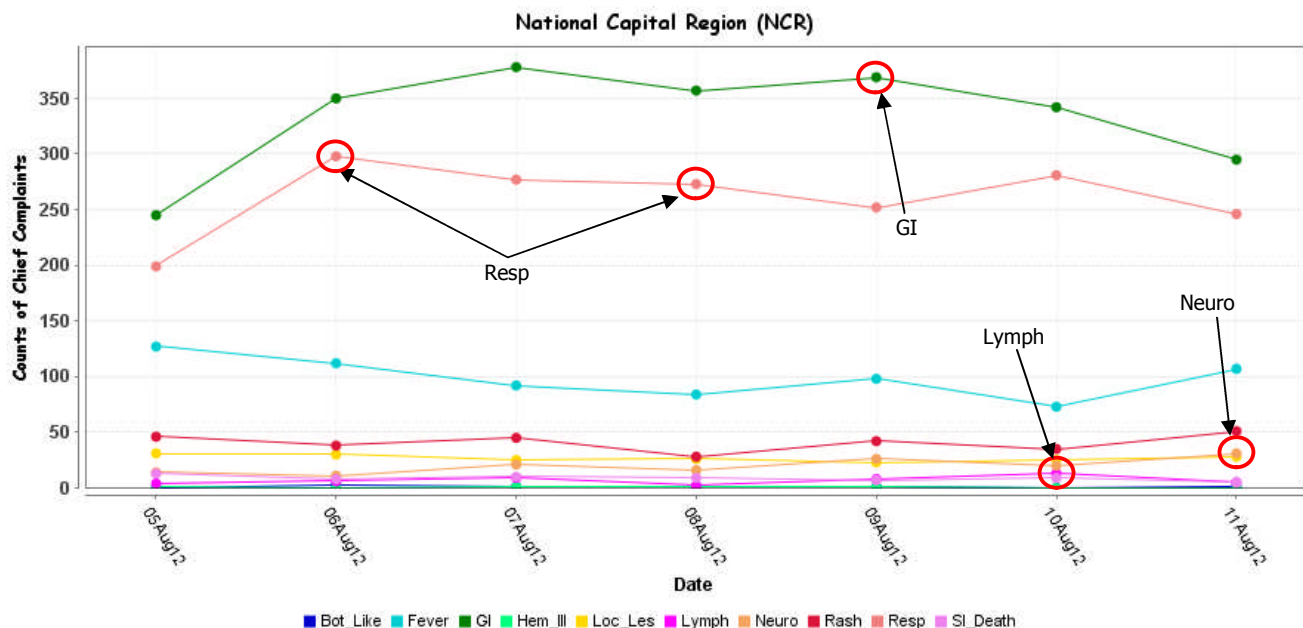
National: No Active Alerts
Maryland: Level One (MEMA status)

SYNDROMIC SURVEILLANCE REPORTS

ESSENCE (Electronic Surveillance System for the Early Notification of Community-based Epidemics):

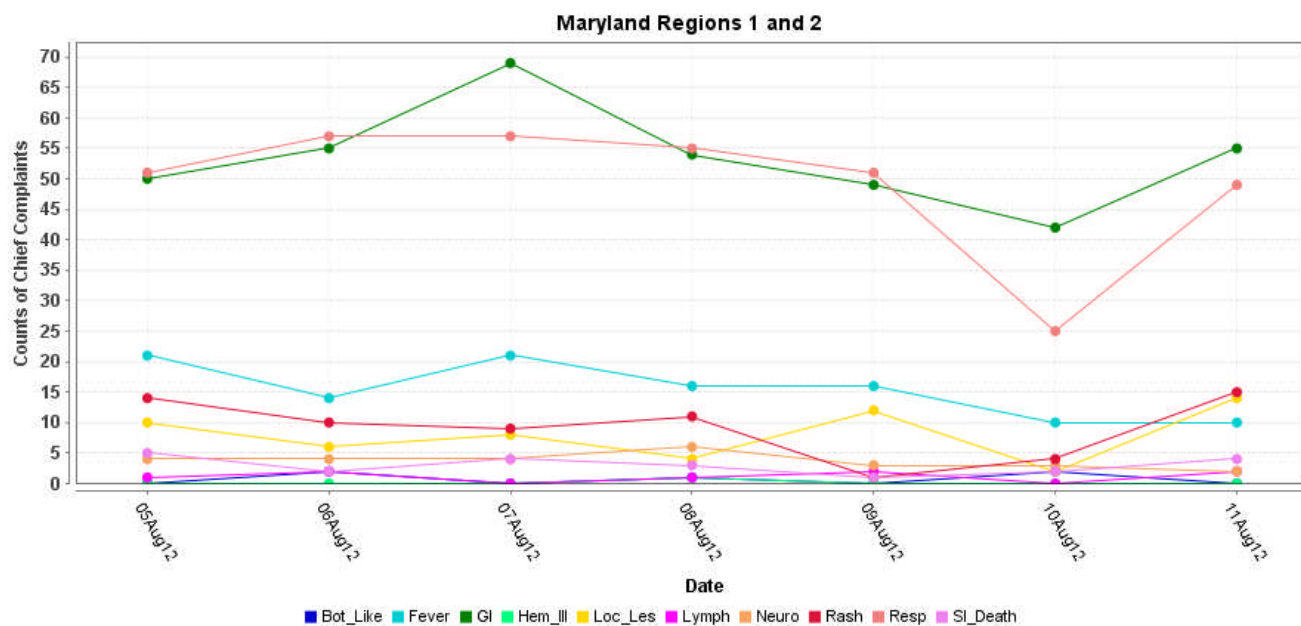
Graphical representation is provided for all syndromes, excluding the "Other" category, all age groups, and red alerts are circled. Red alerts are generated when observed count for a syndrome exceeds the 99% confidence interval. Note: ESSENCE – ANCR uses syndrome categories consistent with CDC definitions.

Overall, no suspicious patterns of illness were identified. Track backs to the health care facilities yielded no suspicious patterns of illness.

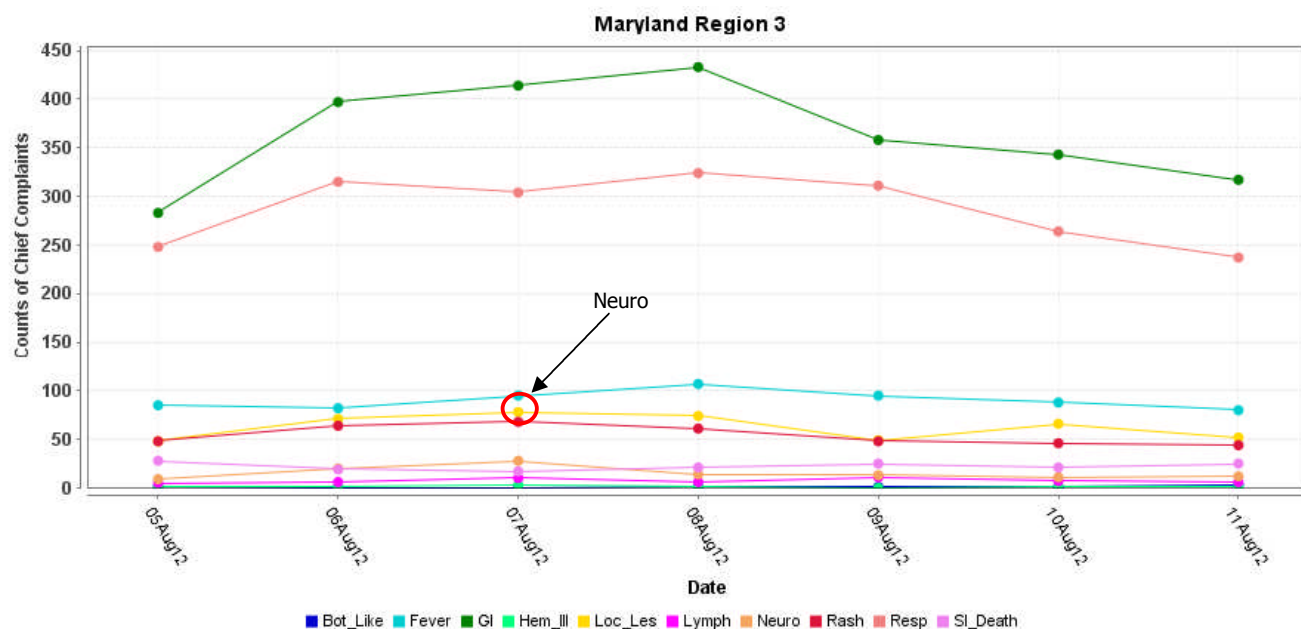


*Includes EDs in all jurisdictions in the NCR (MD, VA, and DC) reporting to ESSENCE

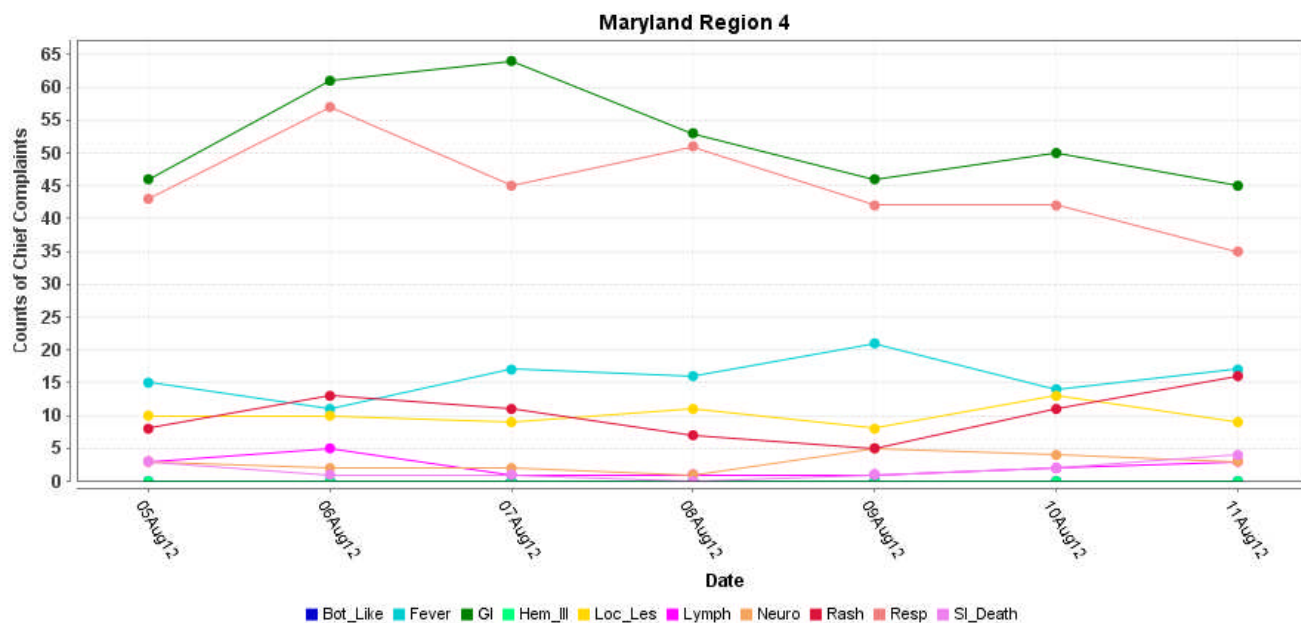
MARYLAND ESSENCE:



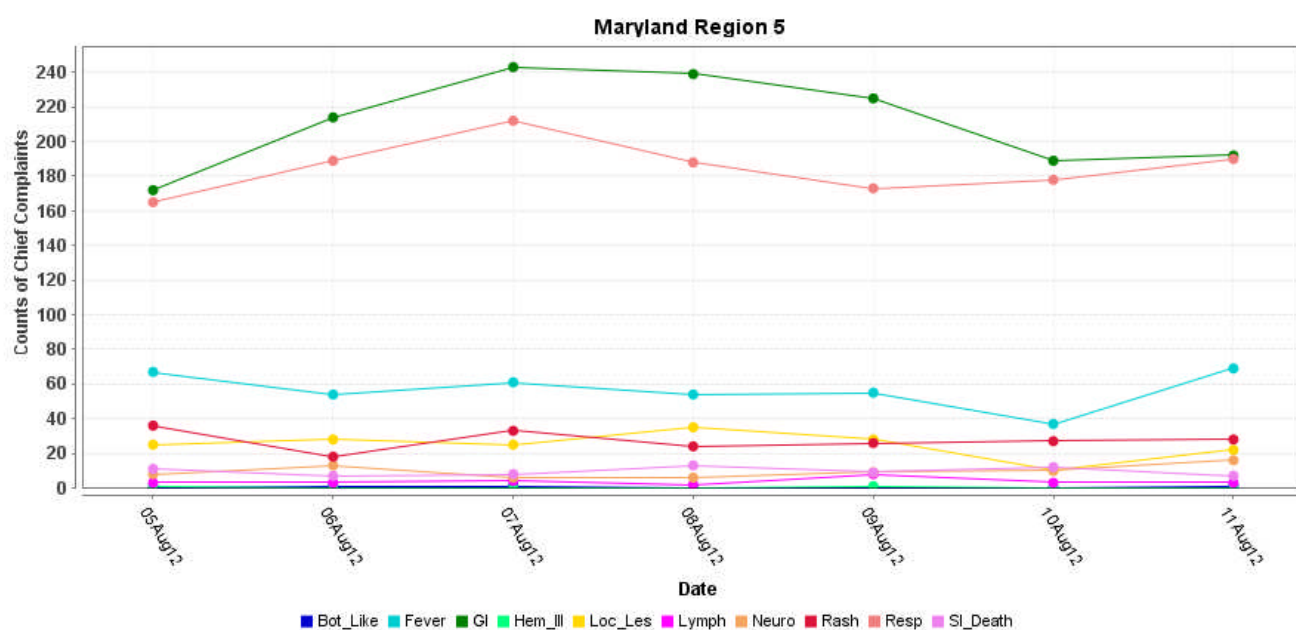
* Region 1 and 2 includes EDs in Allegany, Frederick, Garrett, and Washington counties reporting to ESSENCE



* Region 3 includes EDs in Anne Arundel, Baltimore City, Baltimore, Carroll, Harford, and Howard counties reporting to ESSENCE



* Region 4 includes EDs in Cecil, Dorchester, Kent, Somerset, Talbot, Wicomico, and Worcester counties reporting to ESSENCE

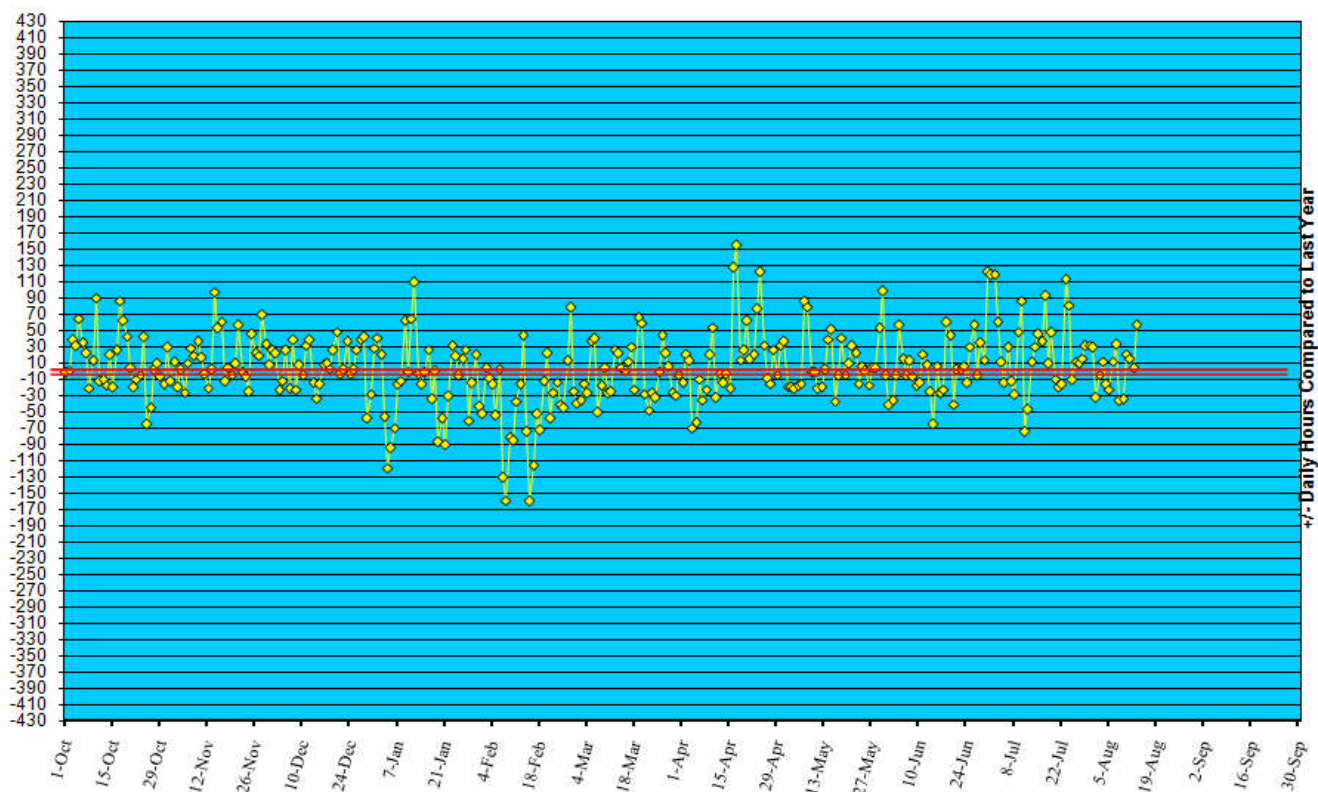


* Region 5 includes EDs in Calvert, Charles, Montgomery, Prince George's, and St. Mary's counties reporting to ESSENCE

REVIEW OF EMERGENCY DEPARTMENT UTILIZATION

YELLOW ALERT TIMES (ED DIVERSION): The reporting period begins 10/01/11.

Statewide Yellow Alert Comparison Daily Historical Deviations October 1, '11 to August 11, '12



REVIEW OF MORTALITY REPORTS

Office of the Chief Medical Examiner: OCME reports no suspicious deaths related to an emerging public health threat for the week.

MARYLAND TOXIDROMIC SURVEILLANCE

Poison Control Surveillance Monthly Update: Investigations of the outliers and alerts observed by the Maryland Poison Center and National Capital Poison Center in June 2012 did not identify any cases of possible public health threats.

REVIEW OF MARYLAND DISEASE SURVEILLANCE FINDINGS

COMMUNICABLE DISEASE SURVEILLANCE CASE REPORTS (confirmed, probable and suspect):

Meningitis:	<u>Aseptic</u>	<u>Meningococcal</u>
New cases (August 5 – August 11, 2012):	12	0
Prior week (July 29 – August 4, 2012):	12	0
Week#32, 2011 (August 6 – August 12, 2011):	11	0

0 outbreaks were reported to DHMH during MMWR Week 32 (August 5 – August 11, 2012)

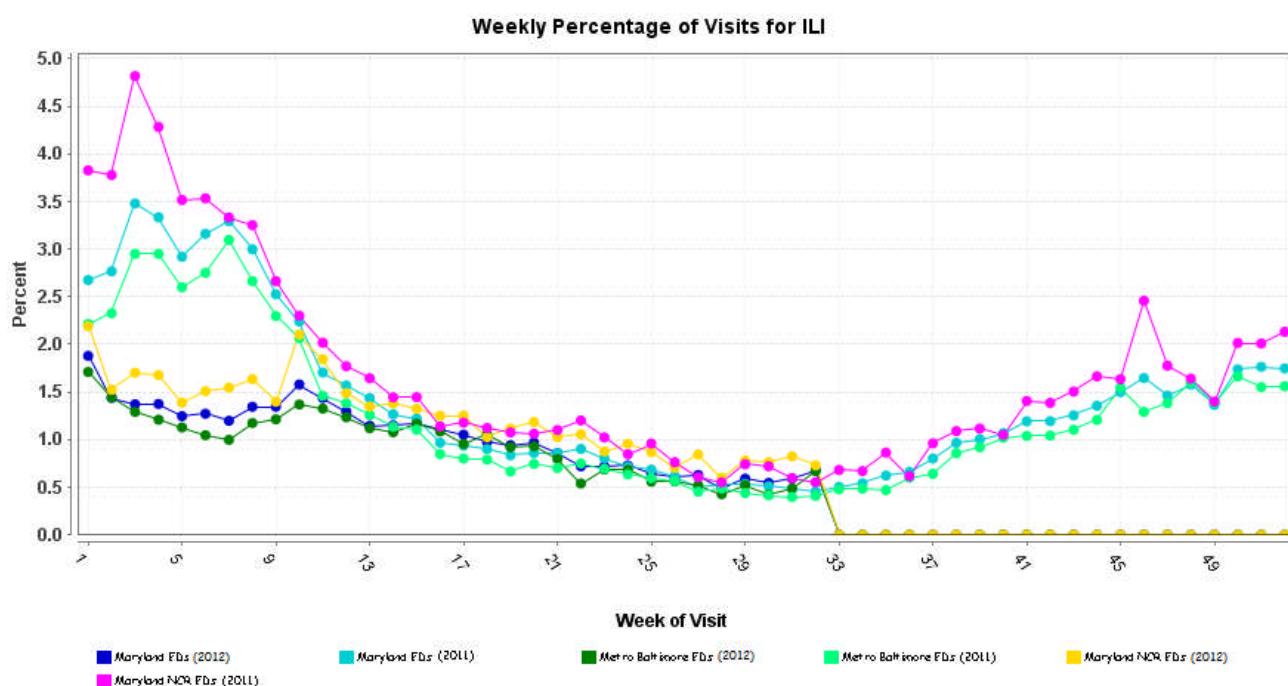
MARYLAND SEASONAL FLU STATUS

Seasonal Influenza reporting occurs October through May.

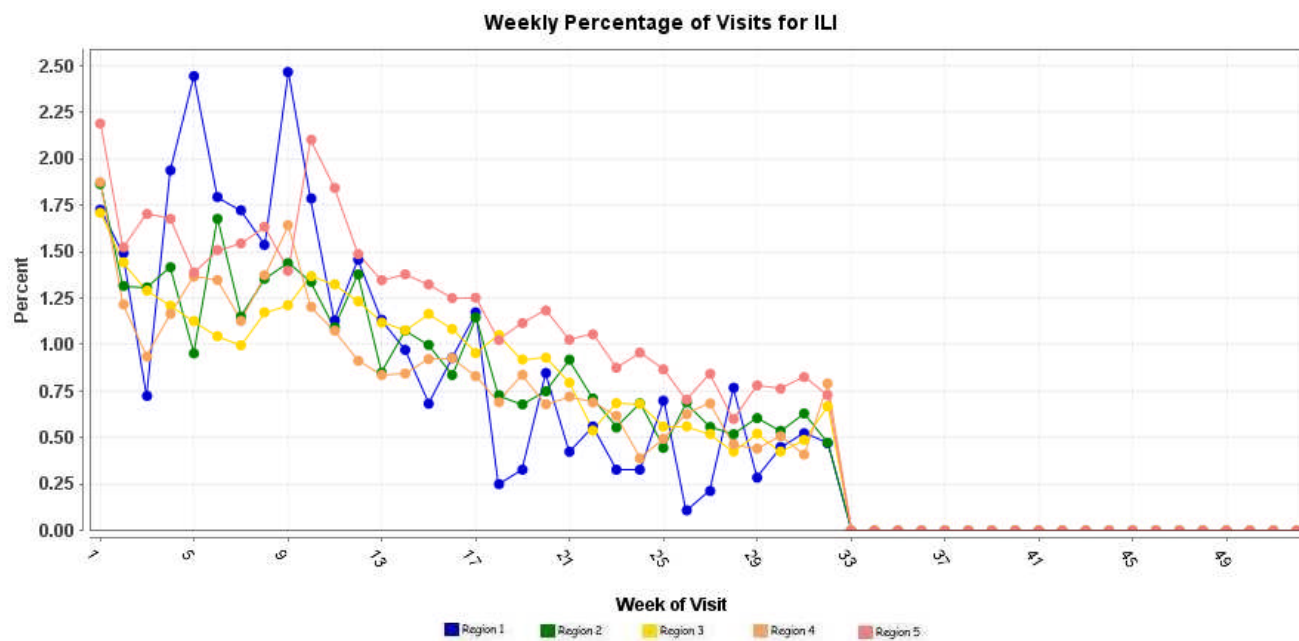
SYNDROMIC SURVEILLANCE FOR INFLUENZA-LIKE ILLNESS

Graphs show the percentage of total weekly Emergency Department patient chief complaints that have one or more ICD9 codes representing provider diagnoses of influenza-like illness. These graphs do not represent confirmed influenza.

Graphs show proportion of total weekly cases seen in a particular syndrome/subsyndrome over the total number of cases seen. Weeks run Sunday through Saturday and the last week shown may be artificially high or low depending on how much data is available for the week.



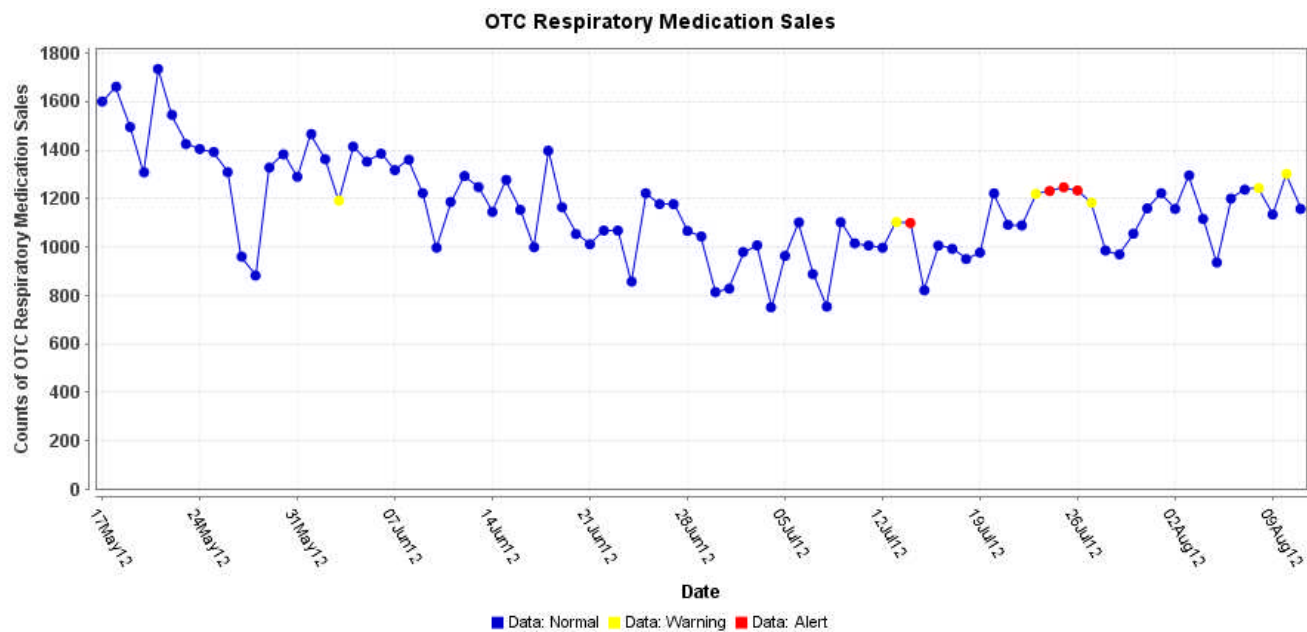
* Includes 2011 and 2012 Maryland ED visits for ILI in Metro Baltimore (Region 3), Maryland NCR (Region 5), and Maryland Total



*Includes 2012 Maryland ED visits for ILI in Region 1, 2, 3, 4, and 5

OVER-THE-COUNTER (OTC) SALES FOR RESPIRATORY MEDICATIONS:

Graph shows the daily number of over-the-counter respiratory medication sales in Maryland at a large pharmacy chain.



PANDEMIC INFLUENZA UPDATE / AVIAN INFLUENZA-RELATED REPORTS

WHO update: The current WHO phase of pandemic alert for avian influenza is 3. Currently, the avian influenza H5N1 virus continues to circulate in poultry in some countries, especially in Asia and northeast Africa. This virus continues to cause sporadic human infections with some instances of limited human-to-human transmission among very close contacts. There has been no sustained human-to-human or community-level transmission identified thus far.

In **Phase 3**, an animal or human-animal influenza reassortant virus has caused sporadic cases or small clusters of disease in people, but has not resulted in human-to-human transmission sufficient to sustain community-level outbreaks. Limited human-to-human transmission may occur under some circumstances, for example, when there is close contact between an infected person and an unprotected caregiver. However, limited transmission under such restricted circumstances does not indicate that the virus has gained the level of transmissibility among humans necessary to cause a pandemic.

As of August 10, 2012, the WHO-confirmed global total of human cases of H5N1 avian influenza virus infection stands at 608, of which 359 have been fatal. Thus, the case fatality rate for human H5N1 is approximately 59%.

AVIAN INFLUENZA (INDONESIA): 10 July 2012, The Ministry of Health of Indonesia has notified the WHO of a new case of human infection with avian influenza A (H5N1) virus. The case is a 37-year-old male from Yogyakarta province. He developed fever on 24 Jul 2012, was hospitalized on 27 Jul 2012 and died on Mon 30 Jul 2012. Epidemiological investigation on the case found that the case had 4 pet caged birds in his home, which is about 50 metres [54.6 yards] from a poultry slaughter house and near a farm. Infection with avian influenza A(H5N1) virus was confirmed by the National Institute of Health Research and Development (NIHRD), Ministry of Health and reported to WHO by the National IHR Focal Point. To date, the total number of human influenza A(H5N1) cases in Indonesia is 191 with 159 fatalities, 8 (all fatal) of which occurred in 2012.

NATIONAL DISEASE REPORTS*

SALMONELLOSIS (USA): 6 August 2012, A total of 40 persons infected with the outbreak strain of *Salmonella Enteritidis* have been reported from 8 states. The number of ill persons identified in each state is as follows: Maine (1), Massachusetts (3), New Hampshire (2), New York (18), Rhode Island (2), Vermont (11), Virginia (2), and West Virginia (1). 11 ill persons have been hospitalized, and no deaths have been reported. Collaborative investigation efforts of state, local, and federal public health and regulatory agencies indicate that ground beef produced by Cargill Meat Solutions at a single production facility is the likely source of this outbreak. On 22 Jul 2012, Cargill Meat Solutions recalled 29 339 pounds of fresh ground beef products. Consumers should check their refrigerators and freezers for recalled products and not eat them; retailers and food service operators should not serve them. Results of antibiotic susceptibility testing indicate that this strain of *Salmonella* is susceptible to commonly prescribed antimicrobial agents. CDC and state and local public health partners are continuing laboratory surveillance through PulseNet to identify additional ill persons. (Food Safety Threats are listed in Category B on the CDC List of Critical Biological Agents) *Non-suspect case

SALMONELLOSIS (TENNESSEE): 6 August 2012, At least 50 people fell ill after a possible salmonella outbreak at the St. Patrick's Irish Picnic in McEwen. The annual event, held 27-28 Jul 2012, usually brings in about 20 000 people and is a 158-year tradition in Humphreys County. Officials with the State Department of Health said they started hearing about festival goers getting sick just a few days after this year's [2012] picnic. It's news that is hard for event organizers to hear. "I'm just heartbroken that this many people have come down with this problem," said Michael Bradley, who's been involved with the picnic for more than 2 decades. "That's really a concern to us, and we're working with the health department to help them find out what the issue was." Shelley Walker with the Health Department said a few of the reported cases have tested positive for *Salmonella enterica*. At the same time, though, she said they are also interviewing others who attended the festival, but did not become sick. They are testing various food items from the event, but have not identified the source of the illness. Bradley wants people to know that his team works with the health department, even prior to the event, in hopes of avoiding incidents like this. "They do an inspection on all the booths," he said. "We get permitted and scored on every booth, and every booth ranged from a 94 to a 96. Every year, we spend a good bit of money to get our booths up to grade, to make improvements on how we do food handling and food preparation." This year [2012], every booth was in compliance with state health standards. Bradley said that's the most frustrating part -- they still don't know what went wrong. Health officials hope that the tests now being done will shed some light on the source of the illness, but said the reality is that that may never know exactly where it came from. (Food Safety Threats are listed in Category B on the CDC List of Critical Biological Agents) *Non-suspect case

FOODBORNE ILLNESS (COLORADO): 9 August 2012, The foodborne illness outbreak that sickened at least 60 recipients of a meal at the Denver Rescue Mission in July 2012 has been linked to turkey contaminated with *Staphylococcus aureus* bacteria, officials say. According to the Denver Department of Environmental Health, a stool sample from an outbreak victim tested positive for [staphylococcus], pointing to that bacterium as the cause of illness. This discovery matches up with the fact that victims became ill within an hour after eating. While other dishes such as mashed potatoes and a vegetable side were served at the 22 Jul 2012 dinner, the turkey was the suspected source of contamination, since evidence suggests that it was not handled according to sanitation standards. "Poor hygienic practices were linked with preparation of that turkey, as well as temperature abuse after it was prepared," said Danica Lee, Program Manager at the Denver Department of Environmental Health in an interview with Food Safety News. *Staphylococcus* bacteria are usually found on the skin and nasal passages of humans. They can grow in foods kept at improper temperatures, and cause illness if ingested. Officials say this incident was strictly due to improper handling and not to previous contamination, therefore there is no risk of more illnesses linked to the outbreak. "We have no reason to believe it was anything other than an isolated incident where organizational practices in handling of the food were not followed," says Environmental Public Health Food Supervisor, Abby Davidson in a statement. "These practices were documented and immediately corrected by the Denver Rescue Mission's leadership and staff." (Food Safety Threats are listed in Category B on the CDC List of Critical Biological Agents) *Non-suspect case

INTERNATIONAL DISEASE REPORTS*

EBOLA HEMORRHAGIC FEVER (UGANDA): 5 August 2012, Health officials in Uganda's Kagandi Hospital have so far confirmed 8 new cases of Ebola. Statistics released by Health officials on Friday [3 Aug 2012] indicate that the number of people currently "actively being followed up" has increased from 232 to 253 in the recent 24 hours. Speaking on the matter, the chairman of the Ebola National Task Force, Mr. Anthony Mbyonye said, "Of the 46 samples

collected since the outbreak began, by 2 Aug 2012, 8 of them were confirmed positive and all are from Kibaale." Uganda's Health Minister, Dr. Christine Ondo revealed that out of the 312 civilians who were earlier confirmed to have been in contact with the sick and the dead, 253 of them were being closely monitored in connection with the transmission of the deadly virus. Meanwhile, the country's World Health Organisation [representative], Dr. Joakin Saweka said that the situation is being closely monitored and there's no need for alarm in issuing any travel advisories against visiting Uganda. He assured the public that the situation was under control with enough structures put in place by the Ugandan government. The assurance came after continued international media attention which seemed to portray Uganda as a country in dire need of assistance, terming the situation as "deadly". Uganda's Tourism Minister Ephraim Kamutu backed the remarks, questioning, "If it were deadly you would not be here. There are 312 contacts being followed in a population of over 34 million people, is that enough to say that the country is deadly?" Generally, a national task force in Uganda has been formed in conjunction with an inter-ministerial committee established to strengthen and coordinate resources, management and response to the Ebola hemorrhagic fever outbreak. A national task force and an inter-ministerial committee have been established to better coordinate resources, response and management of the Ebola hemorrhagic fever outbreak. (Viral Hemorrhagic Fevers are listed in Category A on the CDC List of Critical Biological Agents)

*Non-suspect case

CRYPTOSPORIDIOSIS (IDAHO): 10 August 2012, The past 10 days the Central District Health Department has seen 19 cases of cryptosporidiosis. During a normal year the health district might see 10 cases. Crypto [Cryptosporidium] is a parasite that can cause diarrhea, abdominal pain, vomiting and fever. It can spread through swimming pools and other recreational water. Crypto cases have been reported in Boise and Meridian, but the disease appears to be widespread in the community. As a result of the outbreak, the health department is urging the public to take precautions to prevent the spread of the disease. The health department has advised area swimming pool operators of the situation and many responded by hyper-chlorinating the pools, a technique that kills the parasite. Still, those efforts can be rendered ineffective when people carrying the disease use recreational waters. "We know the hot weather is driving people to seek relief in area pools, lakes and rivers," Kimberly Link, Program Manager for Communicable Disease Control at CDHD, said in a press release. "If you've been ill with diarrhea we can't emphasize enough how important it is to stay out of recreational waters for at least two weeks after your symptoms resolve." Cryptosporidiosis, commonly known as crypto, is usually spread by accidentally swallowing water that has been contaminated with human stool or animal waste. The most frequent symptom is watery diarrhea with abdominal cramping, which can be accompanied by dehydration, weight loss, abdominal pain, fever, nausea, and vomiting. If people have been in recreational waters and are experiencing persistent, watery diarrhea they are urged to consult their healthcare provider. Once a person is infected, the parasites live in the intestines and are passed in the stool. In most instances, infected persons recover without medication. However, a healthcare provider may choose to use medication in cases that do not improve or when other medical issues exist. Infected persons can continue to spread the disease up to two weeks after diarrhea subsides, so they should avoid activities involving recreational waters. (Water Safety Threats are listed in Category B on the CDC List of Critical Biological Agents)*Non-suspect case

*National and International Disease Reports are retrieved from <http://www.promedmail.org/>.

OTHER RESOURCES AND ARTICLES OF INTEREST

More information concerning Public Health and Emergency Preparedness can be found at the Office of Preparedness and Response website: <http://preparedness.dhmm.maryland.gov/>

Maryland's Resident Influenza Tracking System: <http://dhmm.maryland.gov/flusurvey>

NOTE: This weekly review is a compilation of data from various surveillance systems, interpreted with a focus on a potential BT event. It is not meant to be inclusive of all epidemiology data available, nor is it meant to imply that every activity reported is a definitive BT event. International reports of outbreaks due to organisms on the CDC Critical Biological Agent list will also be reported. While not "secure", please handle this information in a professional manner. Please feel free to distribute within your organization, as you feel appropriate, to other professional staff involved in emergency preparedness and infection control.

For questions about the content of this review or if you have received this and do not wish to receive these weekly notices, please e-mail me. If you have information that is pertinent to this notification process, please send it to me to be included in the routine report.

Zachary Faigen, MSPH
Biosurveillance Epidemiologist
Office of Preparedness and Response
Maryland Department of Health & Mental Hygiene
300 W. Preston Street, Suite 202
Baltimore, MD 21201
Office: 410-767-6745
Fax: 410-333-5000
Email: ZFaigen@dhmm.state.md.us

Anikah H. Salim, MPH, CPH
Biosurveillance Epidemiologist
Office of Preparedness and Response
Maryland Department of Health & Mental Hygiene
300 W. Preston Street, Suite 202
Baltimore, MD 21201
Office: 410-767-2074
Fax: 410-333-5000
Email: ASalim@dhmm.state.md.us

Syndrome Definitions for Diseases Associated with Critical Bioterrorism-associated Agents

Table: Text-based Syndrome Case Definitions and Associated Category A Conditions

Syndrome	Definition	Category A Condition
Botulism-like	ACUTE condition that may represent exposure to botulinum toxin ACUTE paralytic conditions consistent with botulism: cranial nerve VI (lateral rectus) palsy, ptosis, dilated pupils, decreased gag reflex, media rectus palsy. ACUTE descending motor paralysis (including muscles of respiration) ACUTE symptoms consistent with botulism: diplopia, dry mouth, dysphagia, difficulty focusing to a near point.	Botulism
Hemorrhagic Illness	SPECIFIC diagnosis of any virus that causes viral hemorrhagic fever (VHF): yellow fever, dengue, Rift Valley fever, Crimean-Congo HF, Kyasanur Forest disease, Omsk HF, Hantaan, Junin, Machupo, Lassa, Marburg, Ebola ACUTE condition with multiple organ involvement that may be consistent with exposure to any virus that causes VHF ACUTE blood abnormalities consistent with VHF: leukopenia, neutropenia, thrombocytopenia, decreased clotting factors, albuminuria	VHF
Lymphadenitis	ACUTE regional lymph node swelling and/ or infection (painful bubo- particularly in groin, axilla or neck)	Plague (Bubonic)
Localized Cutaneous Lesion	SPECIFIC diagnosis of localized cutaneous lesion/ ulcer consistent with cutaneous anthrax or tularemia ACUTE localized edema and/ or cutaneous lesion/ vesicle, ulcer, eschar that may be consistent with cutaneous anthrax or tularemia INCLUDES insect bites EXCLUDES any lesion disseminated over the body or generalized rash EXCLUDES diabetic ulcer and ulcer associated with peripheral vascular disease	Anthrax (cutaneous) Tularemia
Gastrointestinal	ACUTE infection of the upper and/ or lower gastrointestinal (GI) tract SPECIFIC diagnosis of acute GI distress such as Salmonella gastroenteritis ACUTE non-specific symptoms of GI distress such as nausea, vomiting, or diarrhea EXCLUDES any chronic conditions such as inflammatory bowel syndrome	Anthrax (gastrointestinal)

Syndrome Definitions for Diseases Associated with Critical Bioterrorism-associated Agents
(continued from previous page)

Syndrome	Definition	Category A Condition
Respiratory	<p>ACUTE infection of the upper and/ or lower respiratory tract (from the oropharynx to the lungs, includes otitis media)</p> <p>SPECIFIC diagnosis of acute respiratory tract infection (RTI) such as pneumonia due to parainfluenza virus</p> <p>ACUTE non-specific diagnosis of RTI such as sinusitis, pharyngitis, laryngitis</p> <p>ACUTE non-specific symptoms of RTI such as cough, stridor, shortness of breath, throat pain</p> <p>EXCLUDES chronic conditions such as chronic bronchitis, asthma without acute exacerbation, chronic sinusitis, allergic conditions (Note: INCLUDE <i>acute exacerbation</i> of chronic illnesses.)</p>	<p>Anthrax (inhalational)</p> <p>Tularemia</p> <p>Plague (pneumonic)</p>
Neurological	<p>ACUTE neurological infection of the central nervous system (CNS)</p> <p>SPECIFIC diagnosis of acute CNS infection such as pneumococcal meningitis, viral encephalitis</p> <p>ACUTE non-specific diagnosis of CNS infection such as meningitis not otherwise specified (NOS), encephalitis NOS, encephalopathy NOS</p> <p>ACUTE non-specific symptoms of CNS infection such as meningismus, delirium</p> <p>EXCLUDES any chronic, hereditary or degenerative conditions of the CNS such as obstructive hydrocephalus, Parkinson's, Alzheimer's</p>	Not applicable
Rash	<p>ACUTE condition that may present as consistent with smallpox (macules, papules, vesicles predominantly of face/arms/legs)</p> <p>SPECIFIC diagnosis of acute rash such as chicken pox in person > XX years of age (base age cut-off on data interpretation) or smallpox</p> <p>ACUTE non-specific diagnosis of rash compatible with infectious disease, such as viral exanthem</p> <p>EXCLUDES allergic or inflammatory skin conditions such as contact or seborrheic dermatitis, rosacea</p> <p>EXCLUDES rash NOS, rash due to poison ivy, sunburn, and eczema</p>	Smallpox
Specific Infection	<p>ACUTE infection of known cause not covered in other syndrome groups, usually has more generalized symptoms (i.e., not just respiratory or gastrointestinal)</p> <p>INCLUDES septicemia from known bacteria</p> <p>INCLUDES other febrile illnesses such as scarlet fever</p>	Not applicable

Syndrome Definitions for Diseases Associated with Critical Bioterrorism-associated Agents
(continued from previous page)

Syndrome	Definition	Category A Condition
Fever	<p>ACUTE potentially febrile illness of origin not specified</p> <p>INCLUDES fever and septicemia not otherwise specified</p> <p>INCLUDES unspecified viral illness even though unknown if fever is present</p> <p>EXCLUDE entry in this syndrome category if more specific diagnostic code is present allowing same patient visit to be categorized as respiratory, neurological or gastrointestinal illness syndrome</p>	Not applicable
Severe Illness or Death potentially due to infectious disease	<p>ACUTE onset of shock or coma from potentially infectious causes</p> <p>EXCLUDES shock from trauma</p> <p>INCLUDES SUDDEN death, death in emergency room, intrauterine deaths, fetal death, spontaneous abortion, and still births</p> <p>EXCLUDES induced fetal abortions, deaths of unknown cause, and unattended deaths</p>	Not applicable